MDR Tracking Number: M5-04-1970-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The disputed dates of service 2-17-03 to 2-28-03 are untimely and ineligible for review per TWCC Rule 133.308 (e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. This dispute was received on 3-3-04.

The IRO reviewed office visits, joint mobilization, manual traction, myofascial release, ultrasound, therapeutic exercises, electrical stimulation-unattended, chiropractic manipulation, hot/cold packs, diathermy, electrical stimulation (manual) and manual therapy technique rendered from 3-4-03 to 09-11-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-19-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99215 for date of service 4-30-03 and code 99213 for date of service 5-2-03 had no EOBs submitted by either party. Since neither party submitted EOBs, these dates of service will be reviewed per the 1996 Medical Fee Guideline (MFG). Since the carrier did not provide a valid basis for the denial of this service recommend reimbursement per the 96 MFG E/M Section VI, B:

- Code 99215 – recommend reimbursement of $103.00.
- Code 99213 – recommend reimbursement of $48.00.

CPT code 99080 for date of service 4-30-03 had no EOB submitted by either party. Since neither party submitted an EOB, this date of service will be reviewed per the 1996 Medical Fee Guideline (MFG).

- Code 99080 – This code requires a modifier or documentation to support type of service rendered. Requestor's bill had no modifier; therefore, no review can be rendered and no reimbursement can be recommended.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 4-30-03 and 5-2-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8thth day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

NOTICE OF INDEPENDENT REVIEW DETERMINATION

IRO Certificate #: 5259

TWCC Case Number:
MDR Tracking Number: M5-04-1970-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

April 30, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

42-year-old female with a date of injury on ___. Her injury was to her right shoulder, sprain/strain, neck pain and right arm parathesis. EMG recorded medium neuropathy at the wrist. Conservative treatments, including injections to the right shoulder, have been utilized.

REQUESTED SERVICE(S)

Office visits, joint mobilization, manual traction, myofascial release, ultrasound therapy, therapeutic exercises, electric stimulation (unattended), chiropractic manipulative treatment, hot/cold pack therapy, diathermy, electric stimulation (manual) and manual therapy for dates of service 3/4/03 through 9/11/03.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
According to the Agency for Health Care Policy and Research Guidelines, by natural history this patient should have improved already, prior to the disputed services. Furthermore, according to Drs. Weber and Brown in Braddom's text *Physical Medicine and Rehabilitation*, all therapeutic modalities are generally considered adjunctive treatments, rather than primary curative interventions.